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Specialty Registrar Teaching in GIM-

Palliative Medicine: An Elderly Focus

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Palliative Care Team

Aims and Objectives

- Summarise palliative care approach.

- Look at specific cases
  - 'Typical' elderly patient highlighting multiple issues.
  - Delirium and terminal agitation.
  - Advance care planning.

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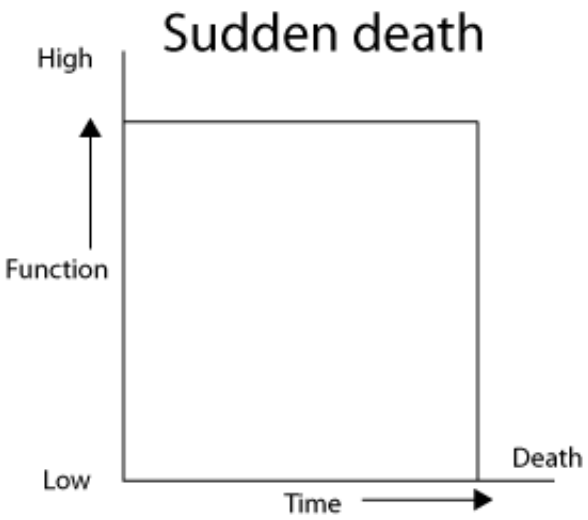

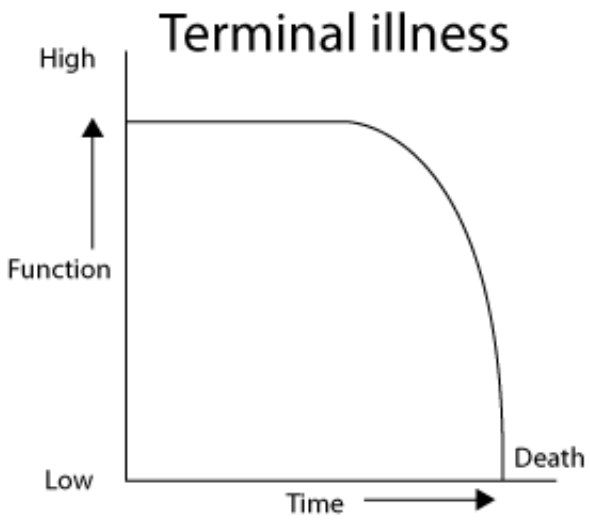

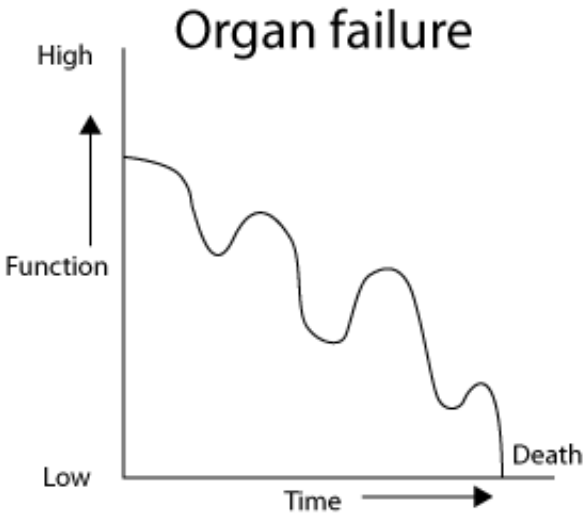

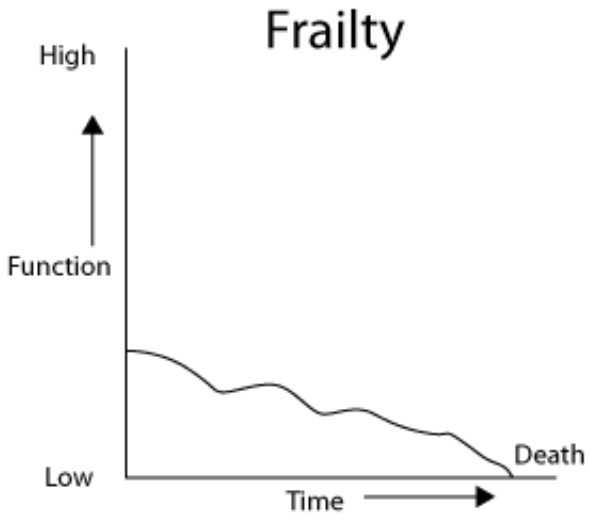

Source: Lynn and Adamson 2003

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Case 1- June

- 85, multiple co-morbidities- osteoporosis, COPD, heart failure, recurrent falls, Parkinson's disease and dementia.

- Nursing home resident, admitted overnight from NH after fall.

- On arrival, acutely unwell- sepsis ?source, ED diagnosed pubic rami fracture.

Considerations

- Uncertain recovery- actively treat & escalation plan.

- Cognitive state at baseline or superadded delirium?
  - Capacity considerations.

- Able to assess pain and need for analgesia?
  - Dosing considerations

- Parkinson's disease and medication management.

Treatment Escalation Plan

- Consider and discuss;
  - Escalation plan
    - Ward based care- appropriate to treat infections?
    - Escalation? To HDU/ ITU/ ventilation etc.
  - CPR

- Review date

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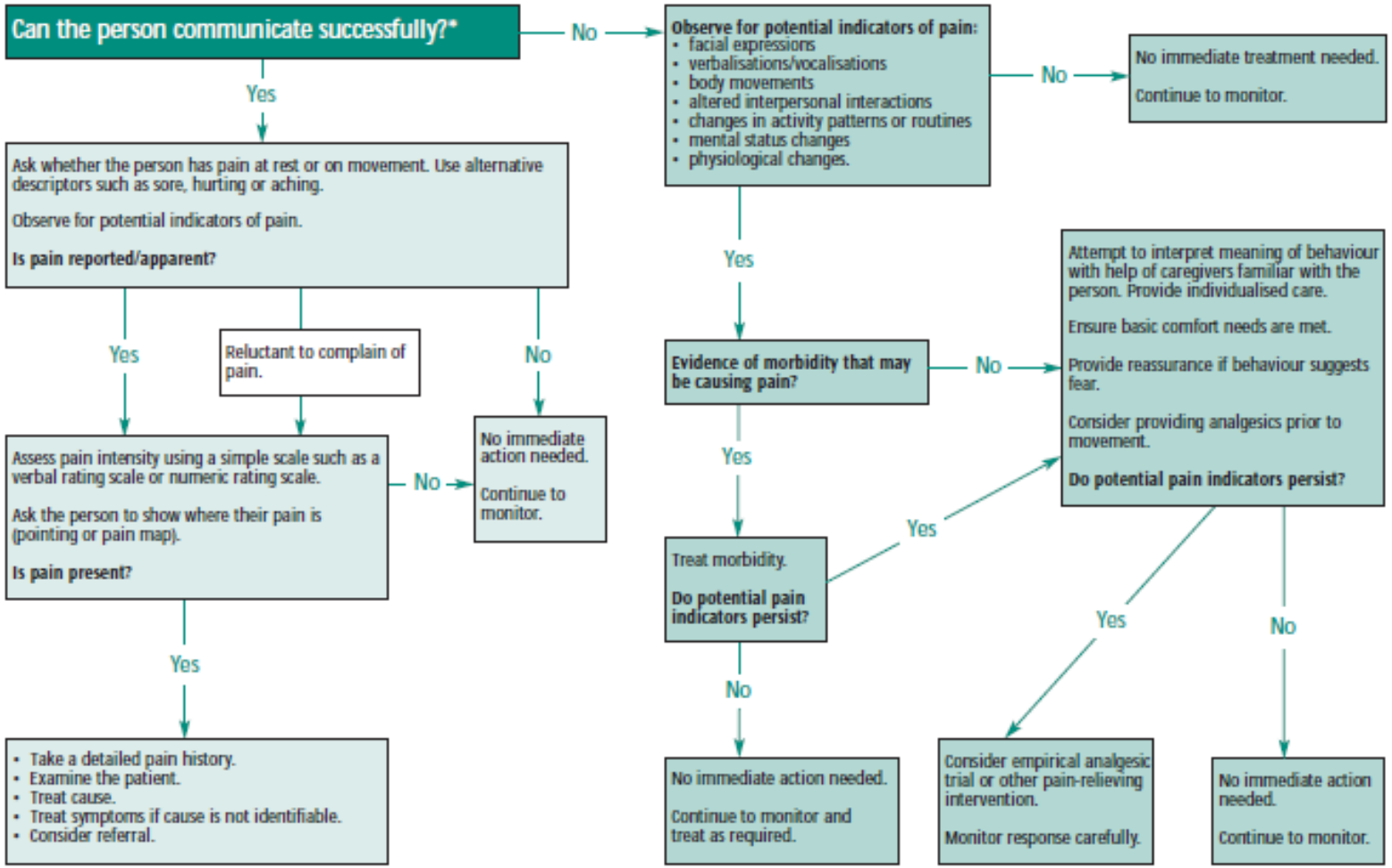
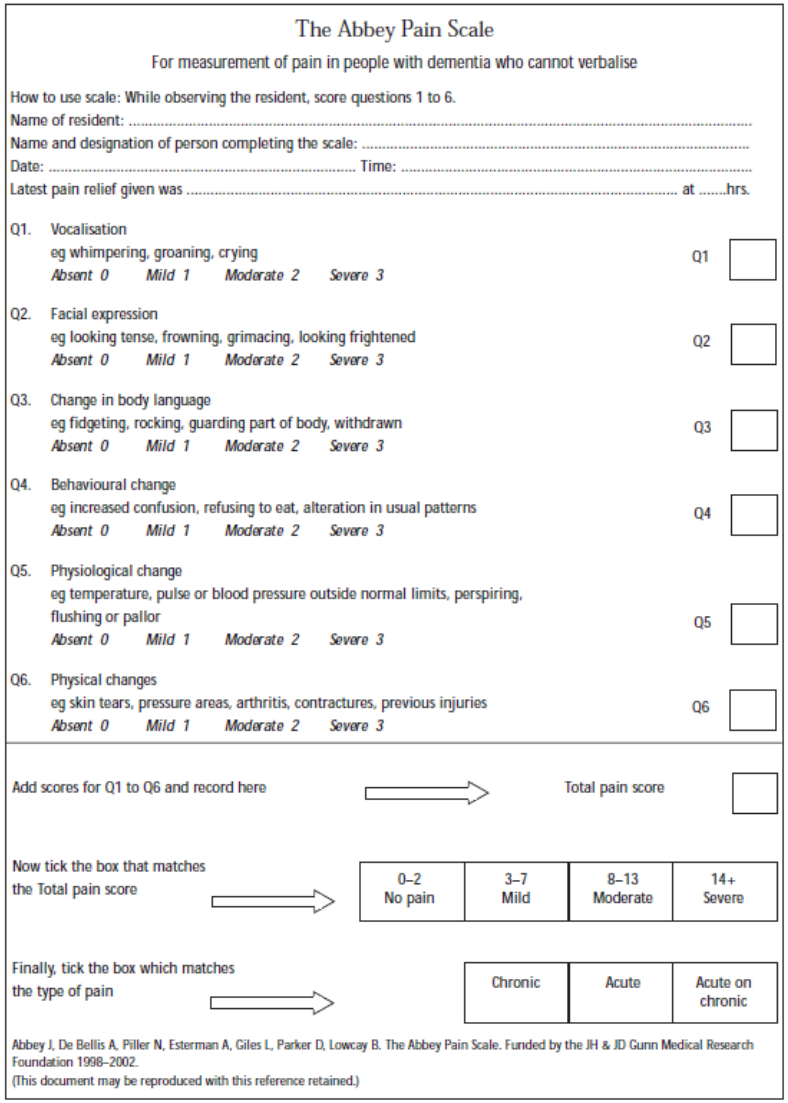
Appendix 2. Algorithm for the assessment of pain in older people



*If there is doubt about ability to communicate, assess and facilitate as indicated in Recommendations 4 and 5 of the Guidelines.

From: The assessment of pain in older patients. National Guidelines.

Abbey Pain Scale



The Abbey Pain Scale

For measurement of pain in people with dementia who cannot verbalise

How to use scale: While observing the resident, score questions 1 to 6.
Name of resident: .....
Name and designation of person completing the scale: .....
Date: ..... Time: .....
Latest pain relief given was ..... at .....hrs.

Q1.	Vocalisation eg whimpering, groaning, crying *Absent 0 Mild 1 Moderate 2 Severe 3*	Q1 ☐
Q2.	Facial expression eg looking tense, frowning, grimacing, looking frightened *Absent 0 Mild 1 Moderate 2 Severe 3*	Q2 ☐
Q3.	Change in body language eg fidgeting, rocking, guarding part of body, withdrawn *Absent 0 Mild 1 Moderate 2 Severe 3*	Q3 ☐
Q4.	Behavioural change eg increased confusion, refusing to eat, alteration in usual patterns *Absent 0 Mild 1 Moderate 2 Severe 3*	Q4 ☐
Q5.	Physiological change eg temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor *Absent 0 Mild 1 Moderate 2 Severe 3*	Q5 ☐
Q6.	Physical changes eg skin tears, pressure areas, arthritis, contractures, previous injuries *Absent 0 Mild 1 Moderate 2 Severe 3*	Q6 ☐

Add scores for Q1 to Q6 and record here ⇒ Total pain score ☐

Now tick the box that matches the Total pain score ⇒

0–2 No pain	3–7 Mild	8–13 Moderate	14+ Severe

Finally, tick the box which matches the type of pain ⇒

Chronic	Acute	Acute on chronic

Abbey J, De Bellis A, Piller N, Esterman A, Giles L, Parker D, Lowcay B. The Abbey Pain Scale. Funded by the JH & JD Gunn Medical Research Foundation 1998–2002.
(This document may be reproduced with this reference retained.)

From: The assessment of pain in older patients. National Guidelines.

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Assessing Distress- DIS-DAT

Disability Distress Assessment Tool

Dis DAT

Please take some time to think about and observe your client's appearance and behaviours when they are both content and distressed, and describe these cues in the spaces given. We have listed words in each section to help you to describe your client or patient. You can circle the word or words that best describe the signs and behaviours when your client or patient is content and when they are distressed. Document the cues in each category and, if possible, give a fuller description in the spaces given. Your descriptions will provide you with a clearer picture of your client's 'language' of distress.

COMMUNICATION LEVEL *

This person is unable to show likes or dislikes	☐ Level 0
This person is able to show that they like or don't like something	☐ Level 1
This person is able to show that they want more, or have had enough of something	☐ Level 2
This person is able to show anticipation for their like or dislike of something	☐ Level 3
This person is able to communicate detail, qualify, specify and/or indicate opinions	☐ Level 4

* This is adapted from the Kidderminster Curriculum for Children and Adults with Profound Multiple Learning Difficulty (Jones, 1994, National Portage Association).

FACIAL SIGNS

Appearance

Information / instructions	Appearance when content	Appearance when distressed
(Ring) the words that best describe the facial appearance	Passive Laugh Smile Frown Grimace Startled Frightened Other:	Passive Laugh Smile Frown Grimace Startled Frightened Other:

Jaw movement

Information / instructions	Movement when content	Movement when distressed
(Ring) the words that best describe the jaw movement	Relaxed Drooping Grinding Biting Rigid Other:	Relaxed Drooping Grinding Biting Rigid Other:

Appearance of eyes

Information / instructions	Appearance when content	Appearance when distressed
(Ring) the words that best describe the appearance	Good eye contact Little eye contact Avoiding eye contact Closed eyes Staring Sleepy eyes 'Smiling' Winking Vacant Tears Dilated pupils Other:	Good eye contact Little eye contact Avoiding eye contact Closed eyes Staring Sleepy eyes 'Smiling' Winking Vacant Tears Dilated pupils Other:

SKIN APPEARANCE

Information / instructions	Appearance when content	Appearance when distressed
(Ring) the words that best describe the appearance	Normal Pale Flushed Sweaty Clammy Other:	Normal Pale Flushed Sweaty Clammy Other:

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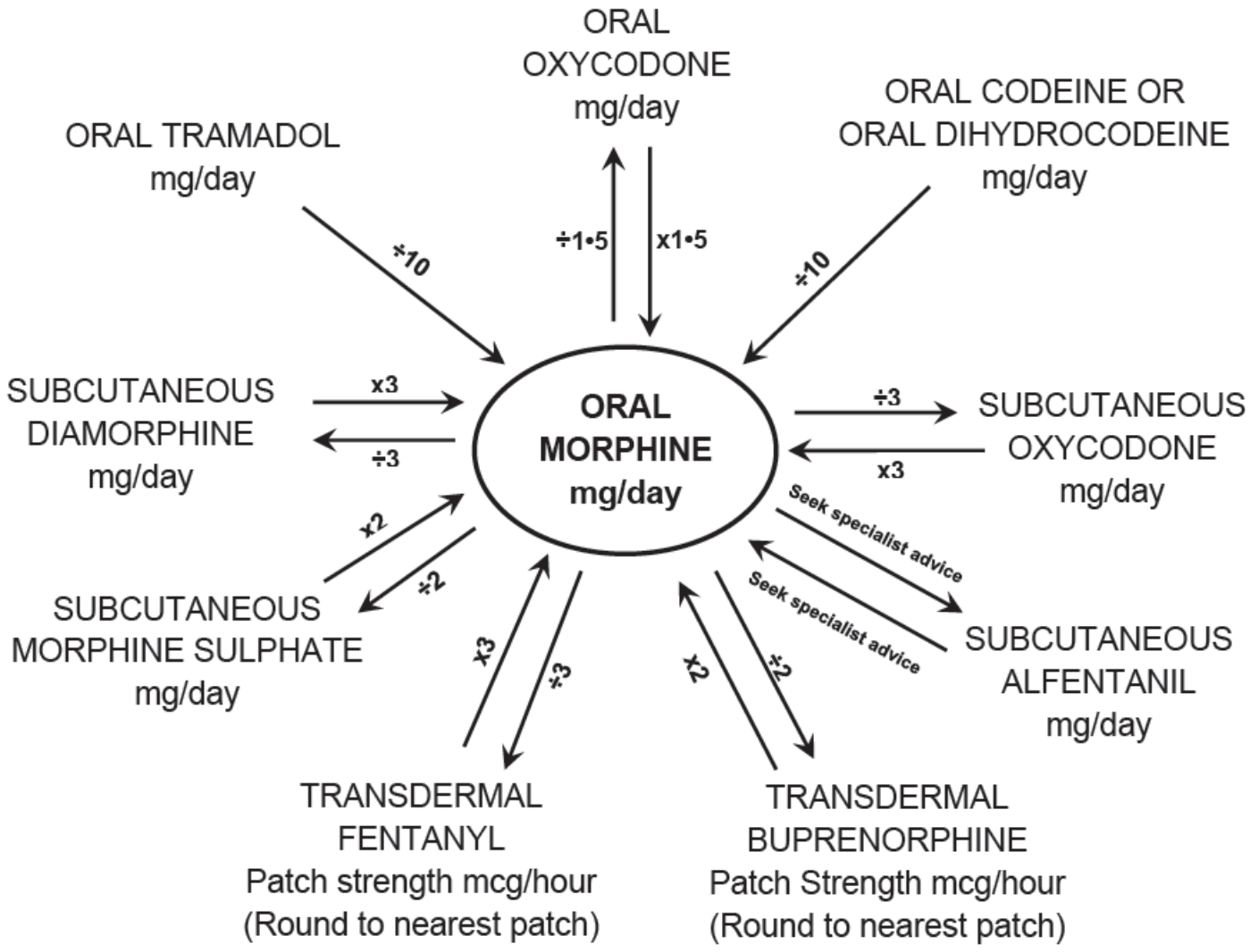
Palliative Care Best Practice Guidance:

The Leeds Opioid Conversion Guide for Adult Palliative Care Patients



Always go through the centre of the chart (via oral morphine) when converting between opioids.

Medication Management

- Opioids and supportive prescribing.

Rationalising medications:

- Drug by drug
- Patient by patient

- Drugs you may/probably want to continue
  - Parkinson's Disease - Anti-epileptics
  - Diabetic medications
  - Oxygen, nebulisers

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Parkinson's Considerations

- PD meds must be continued.

- If unable to swallow
  - Urgent discussions with PD team.
  - Early SALT input.
  - NGT? Can medications be dispersed? Switch to rotigotine patch.

- Specific considerations for medicine choice for other symptoms.

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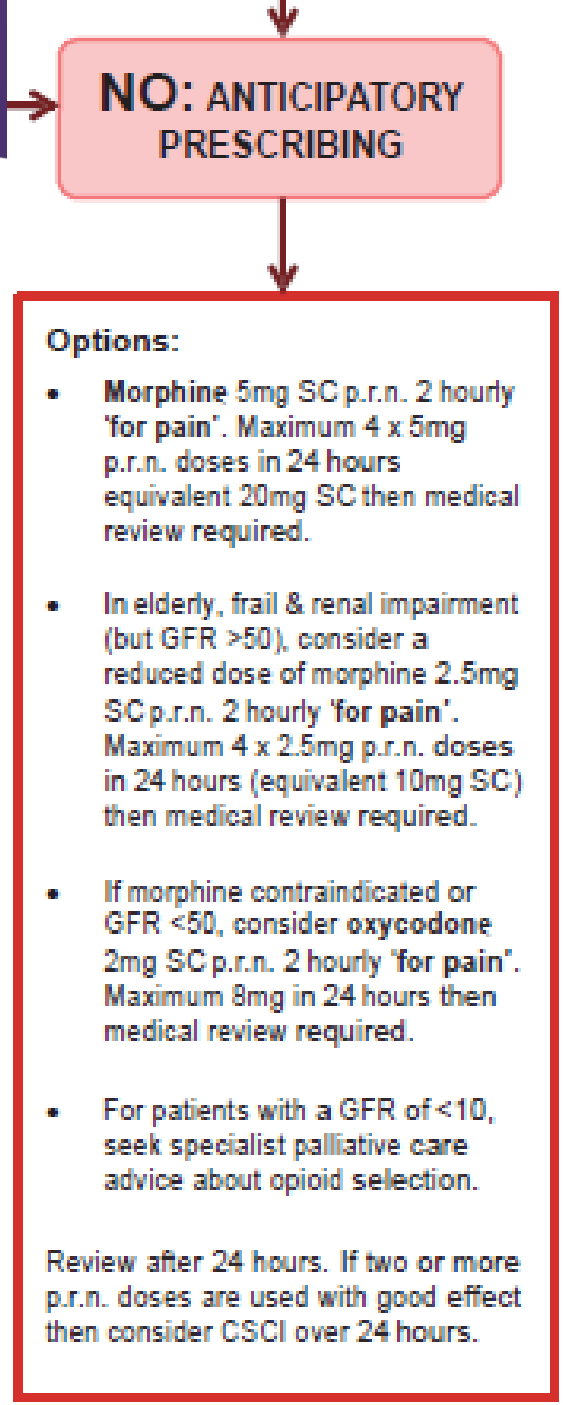
Case 1- June

- Unfortunately despite maximal therapy June continues to deteriorate.

- Discussion with her family that she appears to be approaching the end of her life which they accept.

- Decision to stay in hospital for end of life.



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From: LTHT, Care of the Dying Person care plan

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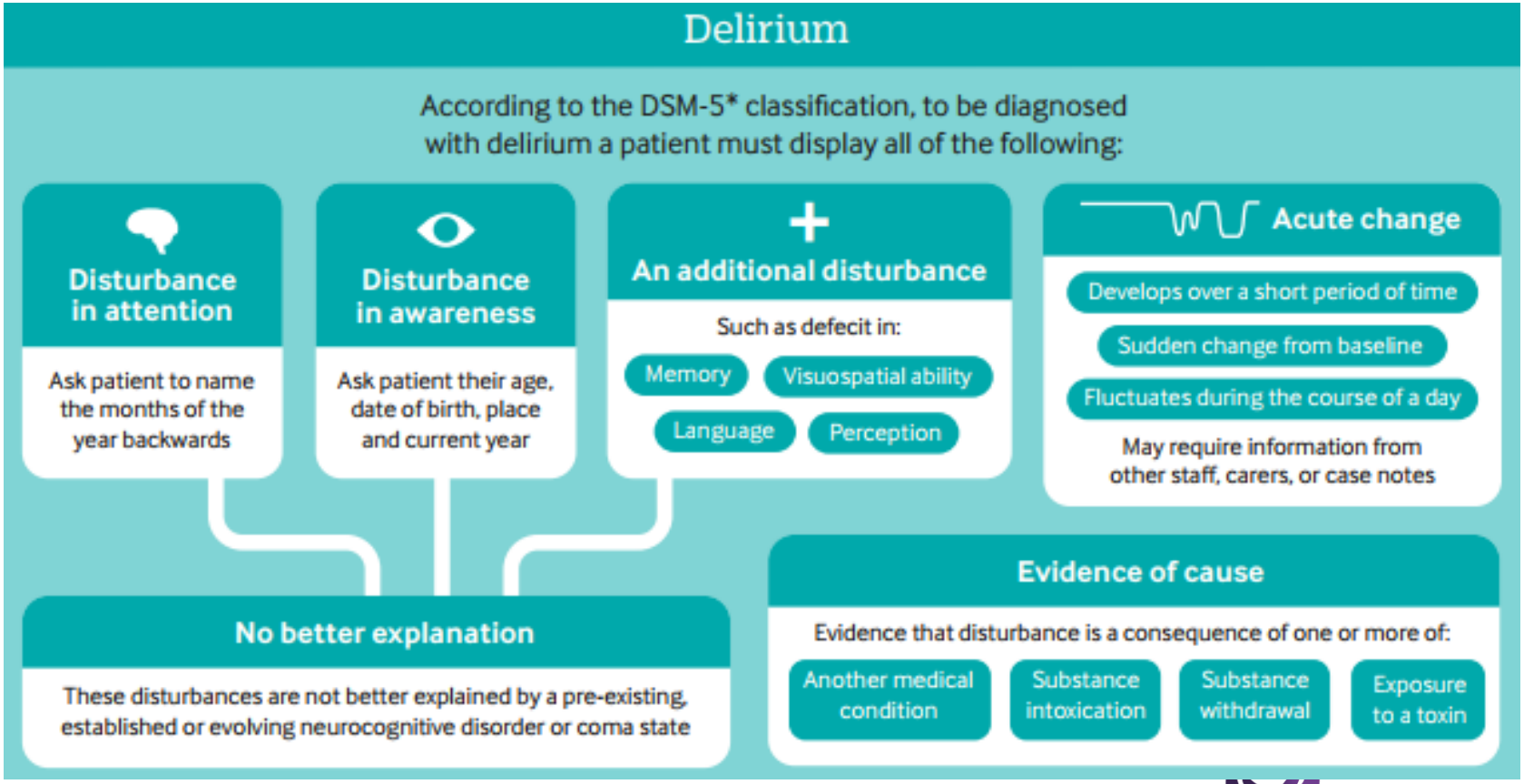
Case 2: Eric

- 82, recently diagnosed with metastatic lung cancer. Seen by oncology, best supportive care.
- Declining over several weeks at home, wife unable to cope and admitted acutely.
- Bedbound, incontinent, not eating and drinking, mainly asleep. Bloods deranged.
- Overnight, becomes acutely distressed, calling out and pulling at bedclothes.

Delirium and Terminal Agitation



Source: Hosker, Ward. BMJ

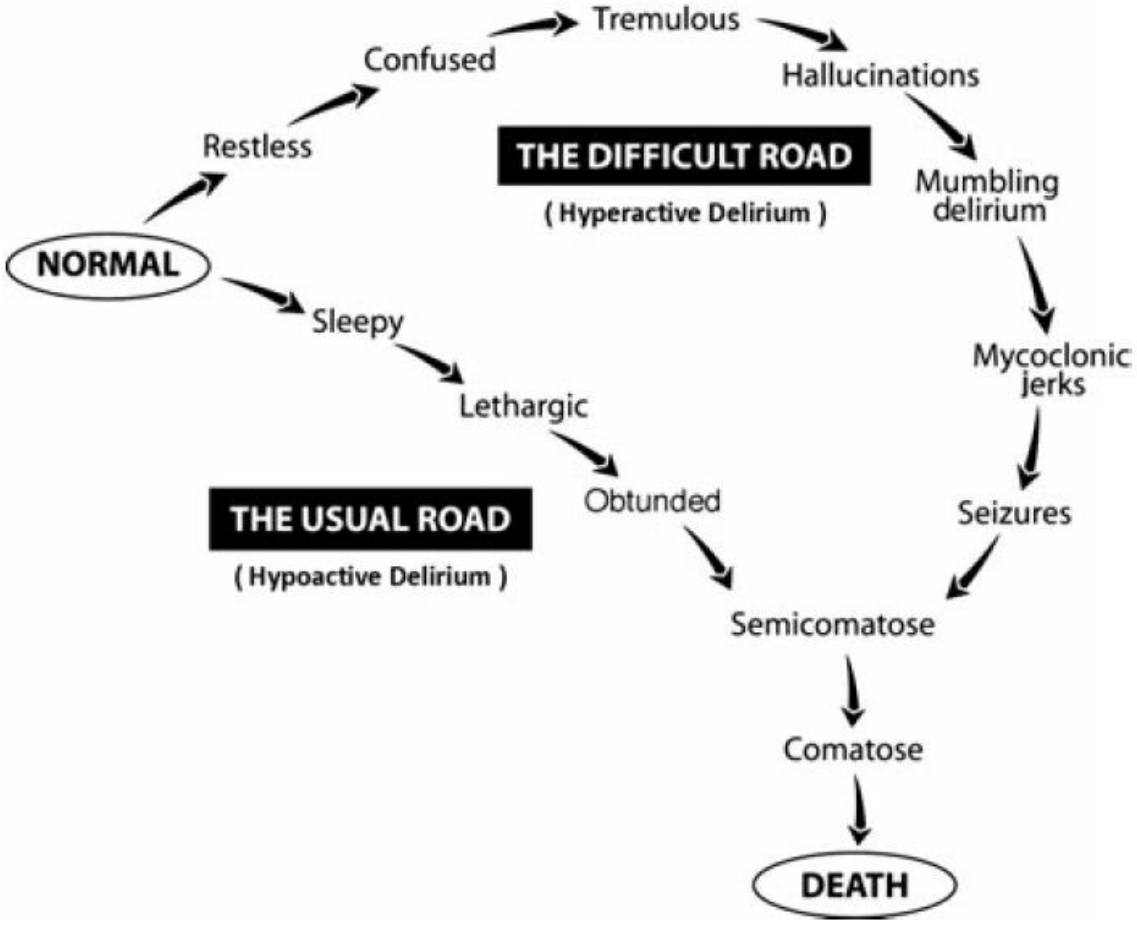


FIG. 1. Common paths to death: hyper- or hypoactive delirium.[137]

JAMA Internal Medicine | Original Investigation

Efficacy of Oral Risperidone, Haloperidol, or Placebo for Symptoms of Delirium Among Patients in Palliative Care
A Randomized Clinical Trial

Meera R. Agar, PhD; Peter G. Lawlor, MB; Stephen Quinn, PhD; Brian Draper, MD; Gideon A. Caplan, MBBS; Debra Rowett, BPharm; Christine Sanderson, MPH; Janet Hardy, MD; Brian Le, MBBS; Simon Eckermann, PhD; Nicola McCaffrey, PhD; Linda Devilee, MBus; Belinda Fazekas, BN; Mark Hill, PhD; David C Currow, PhD

IMPORTANCE Antipsychotics are widely used for distressing symptoms of delirium, but efficacy has not been established in placebo-controlled trials in palliative care.

OBJECTIVE To determine efficacy of risperidone or haloperidol relative to placebo in relieving target symptoms of delirium associated with distress among patients receiving palliative care.

DESIGN, SETTING, AND PARTICIPANTS A double-blind, parallel-arm, dose-titrated randomized clinical trial was conducted at 11 Australian inpatient hospice or hospital palliative care services between August 13, 2008, and April 2, 2014, among participants with life-limiting illness, delirium, and a delirium symptoms score (sum of Nursing Delirium Screening Scale behavioral, communication, and perceptual items) of 1 or more.

Invited Commentary page 42

Supplemental content at jamainternalmedicine.com

CME Quiz at jamanetworkcme.com

When to consider medication:

- Irreversible.
- Patient distressed.
- Patient at risk of harm or harm to others.
- Non-pharmacological approach not working.

Terminal Agitation

- Look for reversible causes and address.
- Clear explanation of symptoms and cause to patient and family.
- Optimise and personalise environment.
- Pharmacological measures if not settling.

Advance Care Planning (ACP)

1. **Think**- about the future - what is important to you, what you want to happen or not to happen if you became unwell
2. **Talk**- with family and friends, and ask someone to be your proxy spokesperson or Lasting Power of Attorney (LPOA) if you could no longer speak for yourself
3. **Record**- write down your thoughts as your own ACP, including your spokesperson and store this safely
4. **Discuss** your plans with your doctor, nurses or carers, and this might include a further discussion about resuscitation (DNAR or Respect) or refusing further treatment (ADRT)
5. **Share this** information with others who need to know about you, through your health records or other means, and review it regularly.

Source: Goldstandardsframework.org.uk

Advance Care Planning

- In hospital care
  - Escalation
  - CPR status

- Long term goals
  - Preferred place of care
  - Preferred place of death

c) Frailty / Dementia – gradual decline

Frailty

Individuals who present with Multiple co morbidities with significant impairment in day to day living and:

- Deteriorating functional score e.g. performance status – Barthel/ECOG/Karnofksy
- Combination of at least three of the following symptoms:
  - weakness
  - slow walking speed
  - significant weight loss
  - exhaustion
  - low physical activity
  - depression.

Stroke

- Persistent vegetative or minimal conscious state or dense paralysis
- Medical complications
- Lack of improvement within 3 months of onset
- Cognitive impairment / Post-stroke dementia.

Dementia

There are many underlying conditions which may lead to degrees of dementia and these should be taken into account. Triggers to consider that indicate that someone is entering a later stage are:

- Unable to walk without assistance and
- Urinary and faecal incontinence, and
- No consistently meaningful conversation and
- Unable to do Activities of Daily Living (ADL)
- Barthel score <3.

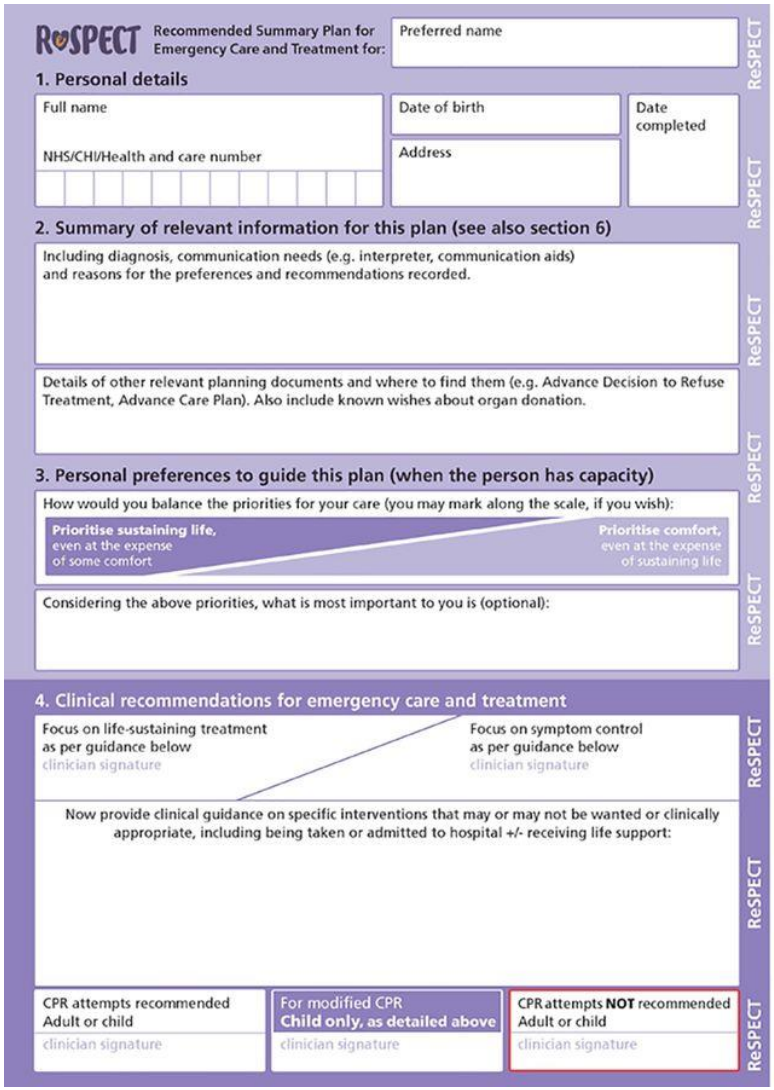
Plus any of the following:

- Weight loss
- Urinary tract Infection
- Severe pressures sores – stage three or four
- Recurrent fever
- Reduced oral intake
- Aspiration pneumonia.

It is vital that discussions with individuals living with dementia are started at an early to ensure that whilst they have mental capacity they can discuss how they would like the later stages managed.

Source: Goldstandardsframework.org.uk

The RESPECT form



ReSPECT Recommended Summary Plan for Emergency Care and Treatment for:

Preferred name

1. Personal details

Full name

NHS/CHI/Health and care number

Date of birth

Address

Date completed

2. Summary of relevant information for this plan (see also section 6)

Including diagnosis, communication needs (e.g. interpreter, communication aids) and reasons for the preferences and recommendations recorded.

Details of other relevant planning documents and where to find them (e.g. Advance Decision to Refuse Treatment, Advance Care Plan). Also include known wishes about organ donation.

3. Personal preferences to guide this plan (when the person has capacity)

How would you balance the priorities for your care (you may mark along the scale, if you wish):

Prioritise sustaining life, even at the expense of some comfort

Prioritise comfort, even at the expense of sustaining life

Considering the above priorities, what is most important to you is (optional):

4. Clinical recommendations for emergency care and treatment

Focus on life-sustaining treatment as per guidance below
clinician signature

Focus on symptom control as per guidance below
clinician signature

Now provide clinical guidance on specific interventions that may or may not be wanted or clinically appropriate, including being taken or admitted to hospital +/- receiving life support:

CPR attempts recommended Adult or child	For modified CPR **Child only, as detailed above**	CPR attempts **NOT** recommended Adult or child
clinician signature	clinician signature	clinician signature

ReSPECT

5. Capacity and representation at time of completion

Does the person have sufficient capacity to participate in making the recommendations on this plan? **Yes / No**

Do they have a legal proxy (e.g. welfare attorney, person with parental responsibility) who can participate on their behalf in making the recommendations? **Yes / No / Unknown**
If so, document details in emergency contact section below

6. Involvement in making this plan

The clinician(s) signing this plan is/are confirming that these recommendations have (circle at least one):

- **A** been recorded after discussion involving this person, who has sufficient mental capacity to participate in making relevant decisions
- **B** where appropriate, been discussed with a person holding parental responsibility
- **C** in the case of a person who does not have sufficient mental capacity to participate in relevant decision-making, been made in accordance with capacity law
- **D** been made without involving the patient (or best interests/overall benefit meeting if the patient lacks capacity)

If **D** has been circled, state valid reasons here. Document full explanation in the clinical record.

Date, names and roles of those involved in discussion, and where records of discussions can be found:

7. Clinicians' signatures

Designation (grade/speciality)	Clinician name	GMC/NMC/ HCPC Number	Signature	Date & time
Senior responsible clinician				

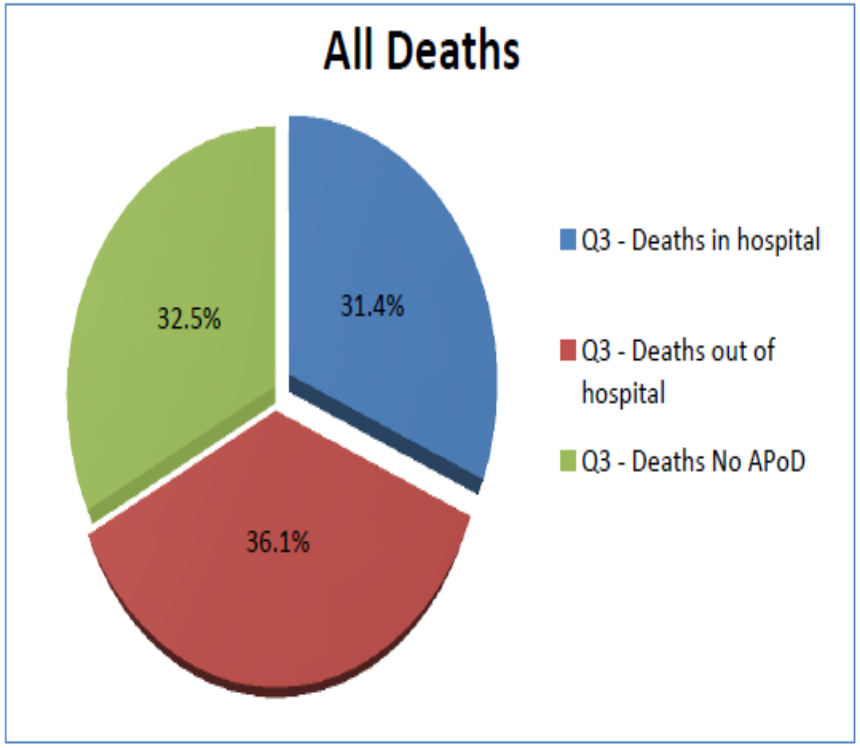
8. Emergency contacts

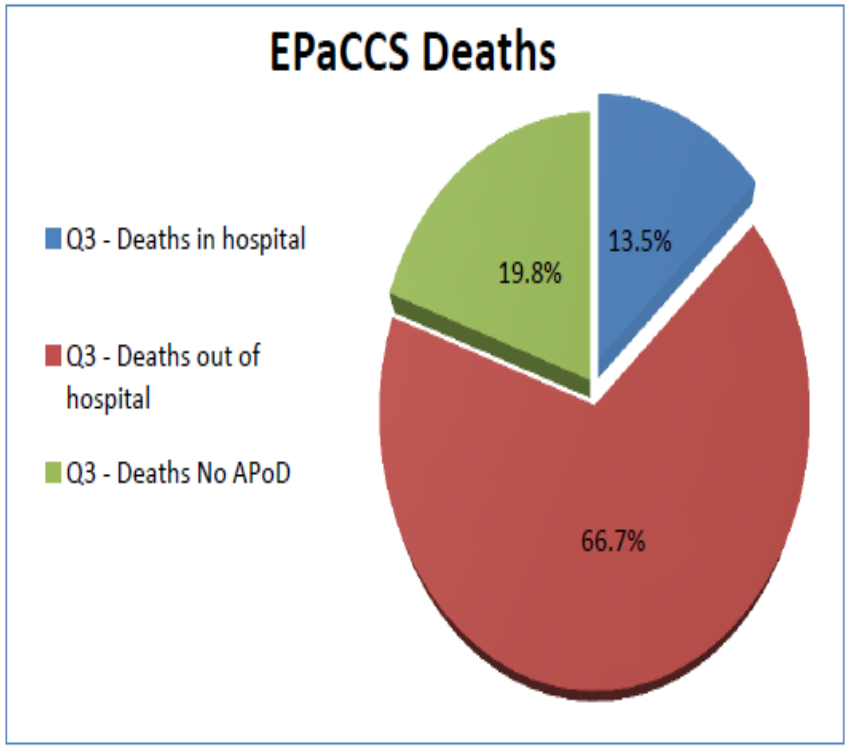
Role	Name	Telephone	Other details
Legal proxy/parent			
Family/friend			
GP			
Lead Consultant			
Other			

9. Confirmation of validity (e.g. for change of condition)

Review date	Designation (grade/speciality)	Clinician name	GMC/NMC/ HCPC number	Signature

Chart 1.1 - Pie chart with percentage deaths in hospital / out of hospital for FY16-17 Q3





Source: Dr Adam Hurlow, Palliative Medicine consultant, LTHT

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Questions?

References

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